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1. Background

- 1.1 In the last ten years, health care associated infection and hospital hygiene has become a public and political concern. Fuelled in part by negative media coverage of ‘dirty hospitals’ and patient stories about the impact of severe MRSA infections, concerns about MRSA became the focus and, in the countries that comprise the United Kingdom, resulted in mandatory surveillance and national and/or local reduction targets.
- 1.2 Between 1990 and 2004 rates of *Clostridium difficile* infection (CDI) increased. It became apparent by 2004/5 that even where reductions in MRSA bacteraemia had been achieved, CDI continued to be an increasing problem. This provided evidence that the measures that were effective at reducing MRSA bacteraemia, namely screening to identify MRSA carriers, topical decolonisation, aseptic technique and management of invasive devices, were different to those required to reduce CDI.
- 1.3 Two large outbreaks of CDI infection at Stoke Mandeville Hospital in 2004 and 2005 associated with the novel 027 ribotype, followed by other outbreaks of similar or greater extent brought recognition that national focus must be extended to include other healthcare associated infections, not just MRSA. In England, there followed a national programme to reduce CDI, in the main through mandatory surveillance, improving cleanliness in hospitals, and promoting prudent antimicrobial prescribing. Similar programmes have been implemented in other UK countries, with reductions achieved.
- 1.4 Investigations into outbreaks in the mid 2000’s highlighted failures that resulted in outbreaks being allowed to continue unchecked (Healthcare Commission 2006, Healthcare Commission 2007). These failures included:
- Lack of surveillance and audit
 - Failure of senior managers of NHS organisations to act on the specialist advice of their infection control teams
 - Poor cleanliness in the hospital environment and poor condition of hospital buildings
 - Lack of prudent antimicrobial prescribing
 - Failure to isolate patients with CDI rapidly and effectively

2. Overview of best practice in infection prevention and control

- 2.1 Publications of best practice standards are not uniform across the United Kingdom; in England, the requirements are laid down in the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance, making the standards a legal requirement; in Scotland, similar standards are identified in the NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection; and in Northern Ireland standards are identified within the Controls Assurance Standard originally published in 2005 and updated in 2009. However, all these publications contain similar messages in that the key to good practice is the need to have a managed environment which minimises the risk of infection to patients, visitors and staff. All identify the need for infection control to be everyone's responsibility but at the same time emphasises the importance of the role of key infection control staff with expert knowledge to guide each member of staff to carry out their role safely. The standards apply to both community and acute services.
- 2.2 Probably the most significant requirement for infection prevention and control is for the Trust Board to ensure that effective arrangements are in place, including an expert lead for IPC, an effective specialist IPC Team and to make IPC an equal or greater priority than other issues, such as financial and other performance targets.
- 2.3 The specialist infection prevention and control team must be appropriately trained, be of adequate size to carry out its function and be supported by adequate secretarial, IT and audit staff.
- 2.4 Attempts have been made in other countries to identify a ratio of IPC practitioners to the number of beds within the organisation. Ratios of 1 IPCN to 250 beds is a common ratio used to determine the human resources required but higher ratios have been suggested (NAO, 2004). However, a ratio based on number of beds is too simplistic and does not take into account the type of organisation and the services it provides nor the increasing complexities in health care treatments. The number of members of the IPC team and the skill mix required is wholly dependent on the type of organisation within which it works. What is crucial, is recognition that a competent team will only be effective in an organisation with a culture that allows it to be effective i.e. one that acts on the expert advice the team provides and enables the team to provide advice directly to those at the highest level of the organisation.
- 2.5 Best practice guidance specific to CDI also exists in each country, the most detailed is an evidence based framework published by DH (England) and HPA in 2008. This emphasises the clinical aspects of CDI prevention and management, including prompt and accurate diagnosis, surveillance, treatment, control strategies such as prudent antimicrobial prescribing, prompt isolation, environmental and hand

hygiene, coping with high prevalence, including the use of designated wards, and governance, audit and performance indicators.

3. Challenges and barriers to effective IPC practice

- 3.1 Barriers to effective IPC practice can be organisational e.g.. inadequate funding of the IPC Team or cultural in that the IPC Team is not enabled or credible at the highest level of the organisation.
- 3.2 Other organisational barriers relate to the way in which health care is organised. Health care in most NHS hospitals involves, for very sound clinical reasons, assessment of patients in admission wards and transfer from that admission unit to a specialty ward. This model may be sound from the perspective of ensuring patients receive assessment from a senior physician on admission but from an IPC perspective it provides the means for unrecognised infection to be transmitted to multiple wards.
- 3.3 Pressure to meet waiting time targets in Accident Emergency can also have a negative impact on IPC practice, if time is not allowed for effective environmental cleaning between patients or does not allow single room accommodation to be created for patients admitted who need isolation nursing.
- 3.4 Other barriers include failure to make adequate facilities available, for instance provision of isolation facilities, resources available for effective environmental and patient equipment cleaning, provision of appropriate hand hygiene facilities to enable compliance with the WHO 5 moments for hand hygiene.
- 3.5 Remaining barriers relate to individuals and their ability or willingness to comply with infection prevention and control practice. This is perhaps best demonstrated in relation to hand hygiene compliance amongst health care workers, where, despite evidence to support the need for hand hygiene at the point of care, health care professionals are often non compliant. This may stem from lack of knowledge or lack of will to be compliant. Where clinicians are convinced of the importance of hand hygiene in preventing infection they are more likely to be compliant. Thus for clinicians to develop good IPC they need the knowledge to inform their practice but also positive role modelling from senior colleagues.

4. Information for patients and their relatives

- 4.1 Providing patients and their relatives with information about standard infection precautions such as hand hygiene is an important part of developing a culture where health care staff perform hand hygiene at the correct moments. The National Patient Safety Agency used the 'It's Ok to Ask' approach as part of the 'Cleanyourhands' campaign and the WHO guidelines for Hand Hygiene in Health Care encourage partnerships between patients their families and healthcare workers to promote hand hygiene (WHO, 2009).

- 4.2 In relation to CDI, affected patients and their families require information to help them understand why they have developed infection and how to minimise risk of recurrence in the future. Thus, provision of information leaflets to supplement oral explanations from clinical staff, are good practice. Such leaflets should include information on risk of recurrent disease, treatment options and risk of severe disease. Information leaflets should include any precautions visitors might have to take to protect themselves, the most critical being hand washing. Unless relatives are involved in providing care to the patient with CDI, personal protective equipment is usually unnecessary. Relatives with risk factors for CDI themselves e.g. those taking antimicrobial therapy should be advised of the increased risk of acquisition.
- 4.3 When facilities are not available to launder patients own faecally soiled night clothes within a hospital, relatives should be advised to launder on the hottest wash possible and to wear gloves when handling soiled clothing and to wash their hands afterwards. Most crucial is the need to advise relatives whether any clothing they remove for laundering is soiled, as it is unpleasant to discover this on opening a sealed bag. Water soluble laundry bags are available which are appropriate for use in domestic washing machines and these allow laundering of soiled clothing without handling first.

5. Surveillance of CDI

- 5.1. Probably the most important area of IPC practice is that of surveillance. This provides the information needed to determine whether IPC practice is of a high enough standard and whether control measures are being effective. However, continuous data collection and reporting via mandatory national systems is only one element of surveillance. The most important element is feeding back results of surveillance at local level, which within a hospital may be to ward or specialty level, on a frequent basis (no less than monthly and more often if prevalence is high) so that individual clinical teams can determine whether there is a problem in their area and take responsibility for investigating why the cases occurred by examining issues such as antimicrobial usage, environmental cleanliness, isolation practices, hand hygiene and commode cleaning. The DH (England) *C.difficile* high impact intervention is an example of a tool that can be used for this purpose.
- 5.2 Having identified areas for improvement, the ward/specialty team and the IPC team should focus on improvement strategies and continue to monitor compliance with best practice until local practice reflects those standards consistently.

References

DH/HPA (2008) *Clostridium difficile* infection: How to deal with the problem Available at <http://www.hpa.org.uk/>

Healthcare Commission (2006) Investigation into outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, Buckinghamshire NHS Trust. Available at <http://www.cqc.org.uk/>

Healthcare Commission (2007) Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust. Available at <http://www.cqc.org.uk/>

National Audit Office (2004) Improving patient care by reducing the risk of hospital acquired infection: A progress report. Report by the Comptroller and Auditor general. HC876 Session 2003-2004: 14 July Available at <http://www.nao.org.uk/>

WHO (2009) WHO Guidelines on Hand Hygiene in Health Care - First Global Patient Safety Challenge Clean Care is Safer Care Available at http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf



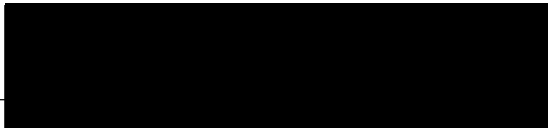
ANNEX A (2)

**EXPERT WITNESS STATEMENT TO THE PUBLIC INQUIRY INTO THE
OUTBREAK OF CLOSTRIDIUM DIFFICILE IN THE NORTHERN TRUST
HOSPITALS**

EXPERT WITNESS NAME: JUDY POTTER

I hereby attach a report dated 15/9/10 which forms my written
statement of evidence to this Inquiry.

I declare that this statement is true and accurate to the best of my knowledge
and belief.

Signed: - 

Date: - 15/9/10

Please return with your report.